Understanding End-of-Life Care Practices

A Project of the IHF University Hospital Special Interest Group (UH-SIG), Conducted by UHC, Secretariat for the IHF UH-SIG
Learning Objectives

• Learn global perspectives about innovative programs and trends of end-of-life care

• Review key findings from research conducted by IHF’s special interest group on end-of-life care issues in university hospitals

• Discuss comparative survey results gathered from cancer centers from the United States and France
Agenda

• Introduction and Moderator:
  – **Barbara Anason**, Senior Vice President, AMC Networks and Strategy, UHC (a Subsidiary of VHA-UHC Alliance NewCo, Inc.)

• Speakers:
  – **Kathleen Vermoch**, MPH, Project Manager and Patient Experience Leader, UHC
  – **Risto Miettunen**, MD, PhD, Chief Executive, Kuopio University Hospital District
  – **Drew A Rosielle**, MD FAAHPM, Palliative Care, University of Minnesota Medical Center, Fairview

• Discussion, questions and answers (All)
EOL Study Objectives

- Promote international knowledge exchange among International Hospital Federation (IHF) member university hospitals relevant to end-of-life (EOL) care services

- Facilitate the collection of baseline information and sharing of approaches used in the delivery and management of EOL care, as well as lessons learned

- Recognize opportunities to improve EOL care at IHF member university hospitals
Responses Per Region and Country – University Hospitals

African/Eastern Mediterranean* (3)
- Pakistan 1
- South Africa 2

Americas: (47)
- Canada 1
- USA 46

European: (19)
- Austria 2
- Belgium 5
- France 1
- Finland 5
- Norway 1
- Portugal 3
- Switzerland 2

Western Pacific: (15)
- Australia 2
- Hong Kong 2
- Japan 3
- Philippines 4
- South Korea 2
- Taiwan 2

All Respondents (N = 84)

* African and Eastern Mediterranean regions are combined due to low responses.

Additional surveys received from 15 Cancer Centers (France N = 6, US N = 9)
Online Survey

- University hospitals and cancer centers responded to questions about:
  - Organizational profiles, EOL models, facilities, services and funding
  - Referral to EOL care, EOL team structure, and staff education and training
  - Performance measures and self-assessment
  - Challenges and barriers encountered
  - Innovations and improvements implemented
- One response per organization
- Timeframe: Current practices 2014
# Survey Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOL Care</td>
<td>Care of terminally ill patients with a life expectancy $\leq 3$ months and <em>not</em> receiving curative therapies</td>
</tr>
<tr>
<td>EOL Services</td>
<td>Include (but are not limited to): comfort care, counseling, care planning, pain management, palliative care, hospice care, spiritual care, bereavement counseling</td>
</tr>
<tr>
<td>Patients</td>
<td>Adult recipients of EOL care</td>
</tr>
<tr>
<td>Family</td>
<td>Individuals closely related to the patient</td>
</tr>
<tr>
<td>EOL Team</td>
<td>Professionals that provide EOL services</td>
</tr>
<tr>
<td>Other</td>
<td>Respondents used open-ended “other” responses for:</td>
</tr>
<tr>
<td></td>
<td>- Euthanasia and/or physician-assisted suicide practices (where legally applicable)</td>
</tr>
<tr>
<td></td>
<td>- EOL services available outside of the university hospital</td>
</tr>
</tbody>
</table>
SURVEY FINDINGS
Characteristics of Project Participants

<table>
<thead>
<tr>
<th>Organizational Profiles</th>
<th>All UH (N = 84)</th>
<th>African/East Med (N = 3)</th>
<th>Americas (N = 47)</th>
<th>European (N = 19)</th>
<th>West Pacific (N = 15)</th>
<th>US CCs (N = 9)</th>
<th>FR CCs (N = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals</td>
<td>55%</td>
<td>67%</td>
<td>43%</td>
<td>84%</td>
<td>53%</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>45%</td>
<td>33%</td>
<td>57%</td>
<td>16%</td>
<td>47%</td>
<td>78%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>67%*</td>
</tr>
<tr>
<td>Median occupied adult beds</td>
<td>606</td>
<td>780</td>
<td>517</td>
<td>787</td>
<td>900</td>
<td>168</td>
<td>204</td>
</tr>
<tr>
<td>Inpatient EOL/ Hospice Unit</td>
<td>30%</td>
<td>33%</td>
<td>23%</td>
<td>42%</td>
<td>33%</td>
<td>22%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*Other responses include: cancer center, association, private and public components
Centralized Teams Provide More Than Half of UH EOL Services

What is Your Hospital’s Model for the Provision of EOL Care?
(All UH, N = 84)

- 58%: A centralized team of specially-trained staff provide the majority of EOL services
- 20%: No centralized team, but specially-trained staff provide the majority of EOL services
- 12%: No centralized/specialized EOL team; all/most staff provide EOL services
- 10%: Significant variation in the provision of EOL services
Cancer Center EOL Models Vary by Country

<table>
<thead>
<tr>
<th>Cancer Center EOL Models</th>
<th>All (N = 15)</th>
<th>US (N = 9)</th>
<th>France (N = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centralized team</td>
<td>60%</td>
<td>78%</td>
<td>33%</td>
</tr>
<tr>
<td>No central team, specially trained staff</td>
<td>27%</td>
<td>0%</td>
<td>67%</td>
</tr>
<tr>
<td>All/most staff</td>
<td>13%</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>Significant variation</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Clinical Triggers are Rarely Used for EOL Care Referral

How Are Your Patients Most Often Referred for EOL Services?*
(All UHs: N = 84, CCs N = 15)

* Respondents selected their top 3 referral methods
Patients are Twice as Likely to Die in Critical Care Units in the Americas as Compared to the European Region

Locations Where Terminally Ill Inpatients are Most Likely to Die* (All UHs: N = 84, CCs N = 15)

- University hospital patients are most likely to die in critical care unit(s):
  - Americas = 77%
  - African/Eastern Mediterranean = 67%
  - Western Pacific = 47%
  - European = 37%
- Likely to die in cancer center critical care unit(s): US 78%; France 50%

*Respondents selected the top 3 locations
Availability and Funding for EOL Services is Variable

• Approximately 90% of UH and CC respondents offer:
  – Symptom and pain management, family meetings, and nutritional counseling

• Some services are more commonly available at cancer centers than university hospitals (all):
  – Psychosocial assess/counsel: CCs = 100%, UHs = 86%
  – Non-medical therapies: CCs = 80%, UHs = 44%
  – Legal counseling: CCs = 80%, UHs = 32%

• Government funding is most common in:
  – European region (84%)
  – Western Pacific region (62%)

• US funding varies, but 37% of UH EOL services are funded by private/insurance sources
## Significant Variation in Composition of the Core EOL Team

<table>
<thead>
<tr>
<th>Primary Members of Centralized or Specialized EOL Team</th>
<th>All UH* (N = 57) (%)</th>
<th>Americas (N = 33) (%)</th>
<th>European (N = 12) (%)</th>
<th>Western Pacific (N = 11) (%)</th>
<th>US CCs (N = 7) (%)</th>
<th>FR CCs (N = 6) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending MD</td>
<td>88</td>
<td>94</td>
<td>75</td>
<td>82</td>
<td>100</td>
<td>67</td>
</tr>
<tr>
<td>Resident MD</td>
<td>47</td>
<td>42</td>
<td>50</td>
<td>64</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>EOL RN</td>
<td>81</td>
<td>73</td>
<td>100</td>
<td>82</td>
<td>71</td>
<td>100</td>
</tr>
<tr>
<td>Other RN</td>
<td>32</td>
<td>18</td>
<td>58</td>
<td>45</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>Social Worker</td>
<td>75</td>
<td>85</td>
<td>67</td>
<td>55</td>
<td>86</td>
<td>83</td>
</tr>
<tr>
<td>Psychiatrist/Psychologist</td>
<td>32</td>
<td>6</td>
<td>83</td>
<td>55</td>
<td>43</td>
<td>100</td>
</tr>
<tr>
<td>Spiritual/Religious</td>
<td>61</td>
<td>79</td>
<td>50</td>
<td>27</td>
<td>86</td>
<td>50</td>
</tr>
<tr>
<td>Care Manager</td>
<td>12</td>
<td>15</td>
<td>17</td>
<td>0</td>
<td>29</td>
<td>50</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>30</td>
<td>27</td>
<td>25</td>
<td>45</td>
<td>71</td>
<td>0</td>
</tr>
<tr>
<td>Pain Specialist</td>
<td>39</td>
<td>30</td>
<td>75</td>
<td>27</td>
<td>29</td>
<td>83</td>
</tr>
<tr>
<td>Phys/Occ Therapist</td>
<td>23</td>
<td>6</td>
<td>50</td>
<td>45</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

*African/East Med included only in “All” due to low responses
Percentage of Dedicated EOL Staff

Primary/Core Staff and Volunteers Dedicated to the Provision of EOL Services (Adjusted for Volume of Adult Occupied Beds)

% of EOL Staffing Per All Adult Beds

% of Core Staffs Dedicated to EOL Services | % of Volunteers Dedicated to EOL Services

All | African/Eastern Mediterranean | Americas | European | Western Pacific | All CCs

All UHs: N = 84, All CCs N = 15
Self-Assessment Scores Reveal Marked Variation

Participants scored themselves on their level of agreement with 15 self-assessment statements related to the provision of end-of-life services

<table>
<thead>
<tr>
<th>Weighted Total Self-Assessment Score (Max Obtainable Score = 1.0)</th>
<th>African/Eastern Mediterranean (N = 3)</th>
<th>Americas (N = 47)</th>
<th>European (N = 19)</th>
<th>Western Pacific (N = 15)</th>
<th>US CCs (N = 9)</th>
<th>FR CCs (N = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>0.08</td>
<td>0.04</td>
<td>0.12</td>
<td>0.18</td>
<td>-0.14</td>
<td>0.22</td>
</tr>
<tr>
<td>Minimum</td>
<td>-0.57</td>
<td>-0.54</td>
<td>-0.36</td>
<td>-0.61</td>
<td>-0.57</td>
<td>-0.04</td>
</tr>
<tr>
<td>Maximum</td>
<td>0.64</td>
<td>1.00</td>
<td>0.54</td>
<td>0.75</td>
<td>0.72</td>
<td>0.73</td>
</tr>
</tbody>
</table>

- The weighted total score = the sum of responses where strongly agree = 1.00, agree = 0.50, neutral = 0.00, disagree = -0.50, strongly disagree = -1.00, divided by the total number of responses to self-assessment items per organization (Maximum Obtainable Score = 1.0)
- Not applicable responses were excluded
# Self-Assessment Identifies Gaps in EOL Practices

<table>
<thead>
<tr>
<th>Percentage of Strongly Agree or Agree Responses to Self-Assessment Statements</th>
<th>% Agreement (All UHs, N = 84)</th>
<th>% Agreement (All CCs, N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOL services are offered to all/most patients in a <strong>timely manner</strong></td>
<td>37%</td>
<td>30%</td>
</tr>
<tr>
<td>EOL services don’t vary significantly by <strong>patient population</strong> (e.g., trauma vs. cancer)</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Minority ethnicities</strong> are as likely to use EOL services as majority ethnicities</td>
<td>52%</td>
<td>33%</td>
</tr>
<tr>
<td>Robust processes are in place to <strong>assess patient and family satisfaction with EOL services</strong></td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>EOL services are adequately <strong>funded</strong> by the existing payment system</td>
<td>21%</td>
<td>27%</td>
</tr>
<tr>
<td>Robust processes are in place to <strong>evaluate the impact of EOL care</strong> on the overall costs of care</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>It is an organizational priority to <strong>control/reduce the use of aggressive therapies</strong> near EOL</td>
<td>45%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Guidelines/protocols</strong> are in place to <strong>support euthanasia and/or physician-assisted suicide</strong> (where legally applicable)</td>
<td>13% NA=73%</td>
<td>7% NA = 80%</td>
</tr>
</tbody>
</table>
Communications, Cultural and Staff Beliefs, and Lack of Funding are Major Challenges

Barriers or Challenges That Impede/Prevent the Provision of Effective EOL Services*

- Communication between clinicians & pts/fam
- Pt/family cultural beliefs
- Entrenched medical staff beliefs
- Lack of funding for EOL services
- Lack of available EOL staff
- Lack of administrative support
- Poor clinical staff communications
- Inadequate info. systems
- Other
- Financial incentives to prolong survival
- No significant barriers or challenges

*Respondents selected their top 3 challenges or barriers
## Contradictions Between Stated Practices

<table>
<thead>
<tr>
<th>Survey Statements</th>
<th>All UHs* (N = 84)</th>
<th>Americas (N = 47)</th>
<th>% Agreement</th>
<th>European (N = 19)</th>
<th>Western Pacific (N = 15)</th>
<th>US CCs (N = 9)</th>
<th>FR CCs (N = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff are offered ongoing education about discussing EOL issues with terminally ill patients and their families</td>
<td>80%</td>
<td>79%</td>
<td>84%</td>
<td>80%</td>
<td>67%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Challenges/barriers to effective EOL care include “communication issues between clinicians and patients and families”</td>
<td>62%</td>
<td>60%</td>
<td>68%</td>
<td>60%</td>
<td>67%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Required physician training includes essential EOL skills</td>
<td>57%</td>
<td>53%</td>
<td>58%</td>
<td>67%</td>
<td>33%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Most physicians can competently provide EOL counseling services</td>
<td>11%</td>
<td>9%</td>
<td>11%</td>
<td>13%</td>
<td>11%</td>
<td>34%</td>
<td></td>
</tr>
</tbody>
</table>

*African/Eastern Mediterranean regions are included only in “All” due to low responses*
Measures Used to Evaluate EOL Care

- Documentation of advance directives and goals
- Timely provision of care
- Use of aggressive therapies near EOL
- Referrals to palliative care and hospice in the last 6 months of life
- Percentage of patients that die with/without palliative care
- Percentage of non-trauma deaths in critical care
- Utilization of comfort care order sets
- Length of stay and readmissions near EOL
- Satisfaction with EOL care
## Working to Enhance EOL Care All Around the World

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Improvements and Innovations Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liverpool Hospital (Australia)</td>
<td>Established “care plans for dying patients” across the hospital along with an EOL coordinator position to provide education and support</td>
</tr>
<tr>
<td>Cedars-Sinai Medical Center (US)</td>
<td>Use of the ECOG (Eastern Cooperative Oncology Group) score to screen for appropriateness before administering chemotherapy</td>
</tr>
<tr>
<td>Centre Hospitalier Universitaire de Liege (Belgium)</td>
<td>Provides practical training for medical students to prepare them to address palliative and EOL care situations</td>
</tr>
<tr>
<td>The Ottawa Hospital (Canada)</td>
<td>Participates in a regional program working to enhance access to EOL care through education and adherence to standards of care</td>
</tr>
<tr>
<td>Queen Mary Hospital (Hong Kong)</td>
<td>Enhanced psychosocial care screening and timely referral of high-risk patients to social workers and clinical psychologists</td>
</tr>
<tr>
<td>Moffitt Cancer Center and Research Institute (US)</td>
<td>Electronic order set automatically trigger chaplaincy and social work consultation when specialist palliative care consult ordered</td>
</tr>
<tr>
<td>Institut de Cancerologie de L’ouest: Angers and Nantes (France)</td>
<td>Studied criteria for stopping specific anti-cancer treatments and validated a questionnaire for assessing quality of life for terminally ill patients</td>
</tr>
</tbody>
</table>
Conclusions and Learnings

• Opportunities exist to:
  – Enhance the education of physicians and nurses as they are the point of entry into end-of-life services
  – Increase the utilization of EOL services by selected populations (e.g. minority ethnicities and trauma patients)
  – Offer legal counseling and non-medical therapies as routine EOL services
  – Reduce the use of aggressive therapies (e.g., critical care) near EOL
  – Standardize EOL terminology, measures, and practices
  – Network with international colleagues to exchange and adapt innovations
Key Takeaways

• We may be more alike than we realize

• The major challenges to providing effective EOL services are:
  – Communication issues between clinicians and patients/families
  – Patient and family cultural beliefs about death
  – Entrenched medical staff beliefs (e.g., prolong life at all costs)
  – Lack of funding

• It is feasible to conduct an international study of EOL care practices among university hospitals
Project Activities

• Presented preliminary UH survey results to the *IHF Leadership Summit* in Seoul, Korea (November 2014)

• Presented study results by web conference to university hospitals and cancer centers (April 2015)

• Shared customized EOL survey reports with respondents and posted online (May 2015)

• Present final study results to the *IHF 39th World Congress* in Chicago, IL (October 2015)

• Publish article about the study in a special End of Life Care issue of the IHF *World Hospitals and Health Services Journal* (December 2015)
Study Limitations

• No universal definitions exist for palliative, hospice, end-of-life, and/or comfort care

• No standardized metrics or data are available to benchmark EOL services

• The study was limited to the care of terminally ill patients near EOL and not receiving curative therapies

• Responses represent opinions about the EOL services provided to inpatients by a small, convenience sample of university hospitals and cancer centers
  – The opinions of patients and families were not collected
  – Cultural differences could not be fully explored using the survey tool

• Opportunities exist to better define a “university hospital” and to improve survey distribution processes
To Learn More

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For more information about the IHF University Hospital Special Interest Group, visit: www.ihf-fig.org
For more information about UHC, visit: www.uhc.edu

Note: This project was conducted by UHC (a Subsidiary of VHA-UHC Alliance NewCo, Inc.) as the secretariat for the University Hospital Special Interest Group (UH-SIG) of the International Hospital Federation (IHF). UHC’s secretariat position and its conducting of the survey should in no way be construed as its endorsement of the topics addressed in the survey or findings.
<table>
<thead>
<tr>
<th>Participating University Hospitals (African/Eastern Mediterranean, European, and Western Pacific Regions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aga Khan University Hospital</td>
</tr>
<tr>
<td>• AKH Wien - Medizinischer Universitäts campus (General Hospital of Vienna - University Hospital)</td>
</tr>
<tr>
<td>• Alfred Health</td>
</tr>
<tr>
<td>• Antwerp University Hospital</td>
</tr>
<tr>
<td>• Cebu Doctors' University Hospital</td>
</tr>
<tr>
<td>• Central Mindanao University Hospital</td>
</tr>
<tr>
<td>• Centre Hospitalier Universitaire de Liege</td>
</tr>
<tr>
<td>• Centre Hospitalier Universitaire Vaudois</td>
</tr>
<tr>
<td>• Centro Hospitalar Cova da Beira - Hospital do Fundão</td>
</tr>
<tr>
<td>• Centro Hospitalar do Porto</td>
</tr>
<tr>
<td>• Changhua Christian Hospital</td>
</tr>
<tr>
<td>• CHU Timone</td>
</tr>
<tr>
<td>• Coimbra's University Hospital</td>
</tr>
<tr>
<td>• Geneva University Hospitals</td>
</tr>
<tr>
<td>• Groote Schuur Hospital</td>
</tr>
<tr>
<td>• Helsinki University Central Hospital</td>
</tr>
<tr>
<td>• Hopital Erasme</td>
</tr>
<tr>
<td>• Kuopio University Hospital</td>
</tr>
<tr>
<td>• Liverpool Hospital</td>
</tr>
<tr>
<td>• LKH-Universit Ätsklinikum Graz</td>
</tr>
<tr>
<td>• Nippon Medical school</td>
</tr>
<tr>
<td>• Oulu University Hospital</td>
</tr>
<tr>
<td>• Prince of Wales Hospital</td>
</tr>
<tr>
<td>• Queen Mary Hospital</td>
</tr>
<tr>
<td>• Seoul National University Hospital</td>
</tr>
<tr>
<td>• Seoul St. Mary's Hospital, Catholic University of Korea</td>
</tr>
<tr>
<td>• Showa University Hospital</td>
</tr>
<tr>
<td>• Silliman University Medical Center</td>
</tr>
<tr>
<td>• Stavanger University Hospital</td>
</tr>
<tr>
<td>• Steve Biko Academic Hospital</td>
</tr>
<tr>
<td>• Taichung Veterans General Hospital</td>
</tr>
<tr>
<td>• Tampere University Central Hospital</td>
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<tr>
<td>• Teikyo University Hospital</td>
</tr>
<tr>
<td>• Turku University Central Hospital</td>
</tr>
<tr>
<td>• Universitair Ziekenhuis Brussel</td>
</tr>
<tr>
<td>• University Health Service - Diliman</td>
</tr>
<tr>
<td>• University Hospital Gasthuisberg</td>
</tr>
</tbody>
</table>
## Participating University Hospitals (Americas)

- Albany Medical Center Hospital
- Barnes-Jewish Hospital
- Beth Israel Deaconess Medical Center
- Cedars-Sinai Medical Center
- Denver Health Medical Center
- Fletcher Allen Health Care
- Greenville Memorial Hospital
- Harborview Medical Center
- Indiana University Health
- Long Island Jewish Medical Center
- Medical University of South Carolina
- MedStar Washington Hospital Center
- Memorial Hermann Hospital--Texas Medical Center
- Montefiore Medical Center
- NYU Hospitals Center
- Olive View-UCLA Medical Center
- Oregon Health & Science University
- Palmetto Health Richland Hospital
- Robert Wood Johnson University Hospital
- Rush University Medical Center
- San Francisco General Hospital and Trauma Center
- Tampa General Hospital
- Temple University Hospital
- The Ohio State University Wexner Medical Center
- The Ottawa Hospital
- Thomas Jefferson University Hospital
- Tufts Medical Center
- UC Davis Medical Center
- UF Health Shands
- University Hospital
- University of Arizona Medical Center South Campus
- University of Illinois Hospital & Health Sciences System
- University of Iowa Hospitals and Clinics
- University of Louisville
- University of Michigan Health System
- University of Minnesota Medical Center
- University of New Mexico Hospital
- University of North Carolina Hospitals
- University of Pennsylvania
- University of Rochester Medical Center
- University of Texas Medical Branch at Galveston
- University of VA Medical Center
- Upstate University Hospital: Downtown Campus
- VCU Medical Center
- Vidant Medical Center
- Wake Forest Baptist Hospital
- West Virginia University Hospital
## Participating Cancer Centers

### France: The UNICANCER Group
- Centre Georges-Francois Leclerc
- Gustave Roussy Cancer Center
- Institut Universitaire de Cancérologie de Toulouse - Oncopole
- ICM Val D'aurelle
- Institut de Cancerologie de L’ouest: Angers and Nantes
- Institut de Cancérologie Lorrain Alexis Vautrin

### US: The Consortium of Comprehensive Cancer Centers for Quality Improvement (C4QI)
- Arthur G. James Cancer Hospital & Research Institute at The Ohio State University Wexner Medical Center
- City of Hope National Medical Center
- Dana-Farber Cancer Institute
- H. Lee Moffitt Cancer Center and Research Institute
- Memorial Sloan-Kettering Cancer Center
- Seattle Cancer Care Alliance
- USC/Kenneth Norris Jr. Cancer Hospital
- The University of Texas MD Anderson Cancer Center
- University of Miami Health System - Sylvester Comprehensive Cancer Center
Recognizing the Expert Support of These IHF Individuals

- **IHF University Hospital Special Interest Group Steering Committee:**
  - Eric de Roodenbeke, IHF
  - David Dean, The Health Roundtable, Australia
  - Thomas Dolan, IHF
  - Salim Hasham, Aga Khan University Hospital, Pakistan
  - Yoon Soo Kim, MD, Korean Hospital Association, Korea
  - Shou-Jen Kuo, MD, Changhua Christian Hospital, Taiwan
  - Risto Miettunen, MD (vice chair), Kuopio University Hospital, Finland
  - Marc Noppen, MD, UZ Brussels, Belgium
  - Sara Perazzi, IHF
  - Rulon F. Stacey (UH-SIG chair), formerly of the University of Minnesota Medical Center/Fairview Health Services, USA
  - Irene Thompson (UH-SIG Secretariat), UHC, USA
  - Steven Thompson, formerly of Johns Hopkins Medicine International, USA
Recognizing the Expert Support of These UHC Individuals

- Barbara Anason, VP, strategy & chief marketing officer
- Julie Cerese, senior VP, performance improvement
- Beth Godsey, director, risk adjustment
- Erika Johnson, senior director, strategic research & analytic services
- Fei Jordan, senior analyst, performance improvement
- Cathy Krsek, senior director, quality operations
- Audrey Orr, member support specialist
- Mary Pierson, member support specialist
- Marilyn Szekendi, director, quality research
- Steve Thomas, analyst - data PI, clinical practice advancement center
- Irene Thompson, president and CEO
- Jocelyn Vaughn, project manager, quality research
References

• UHC. University Hospitals and End-of-Life Care: Findings of an International Benchmarking Project. Chicago, IL: UHC; 2015

• UHC. End of Life Care Practices Survey Reports - University Hospitals. Chicago, IL: UHC; 2015

• UHC. End of Life Practices Survey Reports - Cancer Centers. Chicago, IL: UHC; 2015
Kathy Vermoch, MPH
Project Manager, Quality Operations
Imperative Leader, Patient Experience
UHC (a Subsidiary of VHA-UHC Alliance NewCo, Inc.)
vermoch@uhc.edu

Ms. Vermoch is UHC’s imperative leader for improving the patient experience (i.e., inpatient, outpatient, palliative and hospice care). She leads benchmarking studies, collaborative projects, and educational programs on improving healthcare quality, safety, and service; and enhancing palliative and hospice care services.

Ms. Vermoch has been the leader for UHC’s value-based purchasing (VBP and HCAHPS) inpatient hospital experience initiatives and is currently leading a collaborative to help members ensure good communications between caregivers and patients and families.

Ms. Vermoch recently led an International Hospital Federation (IHF) benchmarking project designed to gain an understanding of the end-of-life care practices around the world and promote collaboration and the sharing of best practices.

As a certified medical technologist, microbiology specialist, and clinical laboratory scientist, Ms. Vermoch has extensive clinical and management experience in hospital laboratory medicine and received a MPH degree from Benedictine University. Prior to joining UHC, Ms. Vermoch held the position of Associate Director for Survey Process Development with The Joint Commission.
Disclosure of Relevant Financial Relationships
By Faculty and Planners of Continuing Education Activities

It is the policy of the IIF/AHA/ACHIE to ensure balance, independence, objectivity and scientific rigor in all of its directly sponsored or jointly sponsored Continuing Education (CE) activities. The intention of this policy is to identify potential conflicts of interest, facilitate resolution according to protocols, and ensure that disclosure is provided to participants prior to the beginning of the activity so that learners may formulate their own judgments as to the objectivity of the activity.

All individuals in a position to influence and/or control the content of IIF/AHA/ACHIE directly and jointly sponsored CE activities must disclose to IIF/AHA/ACHIE and subsequently to learners that the individual either has no relevant financial relationships or any financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in the CE activities.

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Relationship: ☐ Concurrent Session Speaker

Do you or any immediate family member have a financial relationship or interest (currently or within the past 12 months) with a proprietary entity? ☐ Yes ☐ No

If Yes, please identify the company and the nature of the financial relationships and compensation below.

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<th>Type of Relationship</th>
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Do you intend to discuss an unapproved/investigative use of a commercial product/device? ☐ Yes ☐ No

If yes, please disclose such references to the learner in the educational activity.

I have read and will adhere to the IIF/AHA/ACHIE Policy on Conflict of Interest Disclosure. I will uphold IIF/AHA/ACHIE standards to insure that balance, independence, objectivity and scientific rigor are maintained in the planning and presentation of this CE activity.

Name: [Signature] Date: July 9, 2015

Please fax or email this document to Megan Angelini by June 22nd, 2015 at (312) 424-0023 or mangelini@ache.org